REWRITE INTENT OF 40-48

- Ensure that quality anesthesia care is provided at home and when deployed
- Implement a uniform CRNA Scope of Practice across the Army
- Provide clear, concise guidance to Commanders and all anesthesia care providers regarding CRNA Scope of Practice in the U.S. Army
- Eliminate unnecessary CRNA supervision
- Acknowledge CRNA judgment
- Maintain or increase appropriate communication between members of the anesthesia team
- Ensure that CRNA Scope of Practice at Training MEDCENs reflects the same Scope of Practice of all other MTFs. This will provide Physician Surgical and Anesthesiology Residents in training with a practice environment that reflects the corporate standard.
- There is an expectation that the changes to AR 40-48 will be implemented in the word and spirit that the document was written. Commanders maintain the authority to deviate from Army Regulation but careful attention to second and third order effects must be considered before exceptions are implemented.

STATEMENT

The AMEDD has operated variably within the boundaries of AR 40-48 since it's writing. The implementation of the new changes in the regulation codify our daily practice, ensures that quality care is preserved and allows us to train as we fight while meeting our mission. A major cornerstone for the success of this rewrite will be the continued support and collaboration of our anesthesia physician leadership and the willingness of our Commanders to ensure its successful implementation.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

"CRNAs will be responsible and privileged for all the necessary components of anesthesia care they provide for all patients regardless of American Society of Anesthesiologist (ASA) category."

This statement simply describes that CRNAs are responsible and privileged for the entire anesthesia process. The regulation begins with patient assessment (to include the assignment of the patients ASA classification), informed consent, the anesthetic plan, and moves through the administration of the anesthetic, necessary interventions and then through perioperative pain control and discharge from the PACU. This section identifies the components of the anesthesia process for which CRNAs are privileged and responsible. The need for CRNAs to seek collaboration and or intervention by physician care providers (Anesthesiologists or other physicians) is described later in the AR.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

"CRNAs are not routinely supervised for ASA I and II patients". What does that mean?

Part 1

CRNAs are privileged for their judgment as well as their clinical expertise. The discretion, responsibility and accountability for determining when an anesthesiologist (or surgeon if an anesthesiologist is unavailable) is required to be consulted for the delivery of anesthetic care of these ASA I and II patients will rest with the CRNA. It is expected that the CRNA will seek consultation, as needed, regardless of the patients ASA classification. Collaboration does require the CRNA to implement input provided from the physician but the CRNA remains accountable for every aspect/decision within the entire case that the CRNA makes. Surgeons are only held accountable for the specific care they direct.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

RNAs are not routinely supervised for ASA I and II patients". What does that me

Part 2

Does this mean that a patient could potentially enter the surgical pathway, be preoped, taken into the Operating Room, be anesthetized, taken to the PACU and discharged without the intervention, consultation or collaboration of an Anesthesiologist? Yes. This could occur even in an MTF where an anesthesiologist is assigned and physically present for duty. HOWEVER, there will be ASA I and II cases where the CRNA will seek consultation from an anesthesiologist (surgeon if no anesthesiologist available). Complex surgeries, difficult airways, and any other aspects of care that the CRNA determines will be benefited by consultation will be presented. The goal is to place the responsibility for the determination of when the consultation is required squarely on the CRNA.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

Does this mean that an anesthesiologist should not/can not be involved in the care of ASA I or II patients when CRNAs are assigned to the case?

No, the intent is to always maintain a collegial and collaborative relationship. CRNAs may proceed without intervention (and should be allowed to) as long as the patient is of ASA classification I or II and the care being provided is safe. The CRNA is expected to seek collaboration when needed and the anesthesiologist is expected and authorized to engage, to the extent needed, if they determine the care being provided is unsafe. Unnecessary involvement (micromanagement) is to be avoided. Team care with a focus on the patient is expected. A further intent of the AR is to give anesthesiologists relief from mandatory involvement in ASA I and II cases. When a CRNA provides care for these patients without the involvement of an anesthesiologist, the anesthesiologist bears no accountability in the case. Recognizing that the CRNA may consult and further, that the anesthesiologist may engage, in any case, at any time if he/she identifies that care is unsafe.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

What responsibility/accountability does an anesthesiologist have if the CRNA calls for assistance at a difficult or disastrous moment in the middle of a case?

The physician's accountability begins when the physician enters the case and takes responsibility for making patient care decisions. There is no accountability for actions/decisions taken or made by the CRNA prior to the anesthesiologist's engagement in the case or follow-on decisions if the anesthesiologist is not consulted.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

Is a CRNA or an anesthesiologist required to respond if another anesthesia provider requests assistance?

Absolutely! Our ultimate commitment and obligation is always to the patient.

All members of the surgical team (CRNAs, anesthesiologists, surgeons…) are required to respond immediately to any request for assistance in patient care.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

How will the Medical Director (anesthesiologist) maintain visibility of the acuity and types of cases being performed in the Operating Room by the anesthesiologists and/or the CRNAs?

The Operating room schedule indicates the types of cases being conducted.
Any time a CRNA is providing care he/she has the responsibility to seek assistance on any case in which they feel they need assistance and are mandated to interface with a physician (anesthesiologist if available) for all ASA III, IV an V patients.

CLARIFICATION AND ANSWERS TO FREQUENTLY ASKED QUESTIONS

Does the Army Surgeon General or the AMEDD leadership believe that CRNAs and anesthesiologists are equally educated and therefore posses the same training and clinical abilities/expertise?

No. If this were the case, the rewritten Army Regulation would identify no requirements on the part of CRNAs to interface with physicians. This regulation is simply allowing CRNAs to work to their fullest potential as Force Multipliers and professionals, but not as an attempt to be substitutes for physicians.

CONCLUSION

The changes in the AR have been made to ensure that quality anesthesia care is performed while at home or forward deployed. The plan is focused on collaborative efforts that utilize each member of our anesthesia team to their fullest. The AMEDD requires a patient focused effort to train, mentor, and educate every provider to the fullest extent possible. This renewed emphasis on team building, improving communication and educational opportunities will only enhance our ability to serve our patients and meet our mission.